Testimony before the Human Services Committee

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Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of Social Services. I appear before you today to testify on several bills that impact the Department of Social Services (DSS).

SB 1022 AAC Providing Incentives to Meet Long-Term Care Goals

This bill would amend the department's existing authority to consider a nursing facility rate change when a facility's actions are being undertaken for the purpose of carrying out the state's Strategic Rebalancing Plan for long-term care services and supports. Specifically, the bill requires the department to increase a facility's rate in any case where a facility voluntarily decreases its bed capacity, either temporarily or permanently. The bill does not provide the Commissioner any discretion to deny such rate increases. Nor does the bill require that the facility permanently decrease its overall licensed bed count despite receiving a higher rate for an unfilled bed.

The Governor and legislature have recognized the need to shift away from institutional care and recently announced the addition of $10 million in bond funding and $3 million in general fund support to the state budget this fiscal year to help nursing facilities "right-size" by diversifying care models, downsizing, and modernizing.

The intent is to implement a strategic, coordinated approach to reducing beds where projections indicate that they will not be needed, and ensuring that nursing facilities diversify their services to reflect the home care trends. A request for proposals to help nursing facilities "rightsize" by diversifying their business models is currently under development.

Furthermore, under the State Balancing Incentives Payment Program, Connecticut will receive an enhanced match rate of 2 percent for non-institutional long-term services and supports funded under Medicaid from this month through September 2015, which boosts the federal reimbursement rate to 52 percent in this area.

These initiatives currently underway have been developed as part of an overall policy strategy to incentivize system restructuring. The proposal in SB 1022 is not in line with this strategy and funds have not been allocated for an additional rate increase.

Finally, the Department is concerned that this policy will result in additional expenditures by allowing nursing facilities to bill for bed hold days. Nursing home providers must hold a client's bed for up to 15 days each time a resident is admitted to a hospital and providers may bill for bed hold days if the nursing home has an occupancy rate of at least 95%. By temporarily reducing nursing home beds, nursing home providers would be able to adjust their facility's occupancy to obtain an increased rate while also being eligible to bill for bed hold days.

For all these reasons, the department cannot support this proposal.

SB 1023 AAC Revenue Retention by Non-Profit Health and Human Services Providers

This bill would allow nonprofit providers of health or human services to retain the full contract amount when a provider's actual expenses were below the contracted amount. Currently, if at the end of the contract period there are funds available above and beyond a provider's actual expenses, the surplus funds are to be returned to the state; or at the discretion of the department the funds may be carried over and used as part of a new contract period if a new, similar contract is executed.

To the extent that contracts are funded with federal dollars, there may be issues with allowing private providers to retain surplus funds. Even if private providers are able to retain surplus state dollars as contemplated under this bill, federal funds would need to be returned.

Finally, while our current contracts with nonprofit providers contain performance measures, the measures tend to be focused on quantity of services provided rather than on the impact of the services. The state would need to reevaluate its nonprofit provider contracts to include performance standards that focus on outcomes.

Finally, given the state's fiscal difficulties, any unexpended dollars should be available to help the state end the year with a balanced budget. Thus, the department cannot support this bill.

SB 1024 AAC Reimbursement of Emergency Room Physicians for Treating Medicaid Patients

This bill would allow emergency Department physicians to enroll independently as Medicaid providers, thereby qualifying for direct reimbursement of professional services provided to Medicaid recipients in hospital emergency departments. Reimbursement would include professional services for Medicaid recipients admitted to hospitals as inpatients on the same day the emergency services are provided. The rate paid would be that currently in effect using applicable Current Procedural Terminology (CPT) codes, adjusted to ensure that there would be no additional cost to the state nor any impact on the rate paid to the hospital. Given some of the additional costs outlined below, this adjustment may be significant.

Currently, DSS pays for emergency department services using three different revenue center codes for: 1) the facility emergency care; 2) the emergency department professional fee; and 3) urgent care (the professional fee for urgent care is included in the facility fee). Revenue center codes include all of the procedures performed by the physician; whereas procedures performed by the emergency physician using CPT codes could be billed in addition to the professional visit fee. For example, the hospital would be paid no more than the standard visit fee if an emergency physician sets a fractured arm under a revenue center code. In contrast, an independently enrolled emergency physician would be paid for the visit and for the setting of the fracture.

In addition, for patients admitted to the hospital on the same day as the emergency department visit, the Department currently includes all charges for the emergency visit in the hospital payment for the first day of the inpatient admission.

This bill would impact professional fees paid by the state in several ways. First, the use of CPT codes by the emergency department physician involves more than the fee for the visit, but also potentially for procedures performed by that physician during the visit. As stated previously, all procedures performed by the physician during the emergency or urgent visit are currently included as a bundled payment in the revenue center code payment to the hospital. The number of procedures performed could be substantial. Unfortunately, the Department is limited in its ability to predict this impact because we do not capture these extra procedures in claims under the current methodology. In addition, paying separately for these procedures could create a financial incentive to perform more of them.

Second, as suggested by the legislation, the emergency department professional fees for patients admitted to the hospital the same day they are seen in the emergency department would create a new cost to the state, since under the current payment structure, all charges for the emergency visit are rolled into the hospital payment for the first day of the inpatient admission. Similarly, the professional fees for many patients admitted for observation, which is frequently provided in the emergency department or in a nearby area staffed by the emergency department, would also represent an additional cost to the state, particularly since the fees paid to the hospital will not change.

The bill envisions that current rates would need to be adjusted to assure that there is no additional cost to the state. The department's actuarial consultants are attempting to determine how the rates could be set in a manner that takes into account the increased charges enumerated above, as well as the likely increased utilization of procedures once these are separately reimbursed. In order to ensure cost neutrality, the current emergency department professional fee would likely need to be adjusted downward to account for the claims for the same day admissions and observation stays. In addition, since the current volume of procedures is unclear and the future volume will likely grow due to the added financial incentive to perform them, the Department may need to pay only the adjusted professional fees for the visits and not the procedures.

Given that the department is currently in the process of replacing the current method of reimbursement with diagnosis related groups (DRGs) for inpatient services and Ambulatory

Payment Classification (APC) for outpatient services, additional changes as required in this bill are not recommended at this time.

SB 1025 AAC Advance Payments to Nursing Facilities for Uncompensated Care

This bill would require the department to make an advance payment to a nursing facility whenever the facility is providing uncompensated services to one or more consumers whose application for long-term care medical assistance has been pending for more than 90 days, or when payment has not been made to the facility within 30 days of an approved application. The bill would limit the advance payment to 50 percent of the estimated amount due. Additionally, the department would recoup the advance payments made within 30 days of payment to the facility or after an application has been denied.

The bill would also delay user fee payments for any days not yet receiving reimbursement due to delayed Medicaid pending status of the client. Finally, the bill would require DSS to pay for the financing cost for the nursing home line-of-credit to cover costs associated with providing uncompensated care.

This proposal would have an estimated cost of approximately $27 million. In addition, the state could not claim federal financial participation (reimbursement revenue to the state) for any payments made for individuals not yet determined eligible.

A long-term care eligibility determination is a highly complex and deeply involved process that requires the cooperation of all stakeholders to complete. Federal Medicaid law requires the imposition of penalties if applicants or their spouses transfer assets for the purpose of qualifying for Medicaid, within five years of applying for long-term care Medicaid services. This requires that DSS eligibility workers review financial transactions for all assets during this five-year period. Merely obtaining all of the financial records, often from family members who are unwilling to share or unable to obtain the records, routinely takes more than 90 days. The subsequent review of the records once they are obtained is a painstaking process which essentially amounts to a forensic accounting by eligibility workers, to ensure that Medicaid dollars intended for low-income individuals are not funding long-term care for those who should not qualify.

We are concerned that passage of this proposal would remove an incentive for the family and nursing facility to complete the application in its entirety. Not completing the application would result in a denial, which would then necessitate a recoupment of payments made to the facility in good faith. In fact, any advance payment made on behalf of an applicant who is later determined to be ineligible, due to inappropriate asset transfers or failure to meet other Medicaid eligibility requirements, would have to be reimbursed to the department.

Second, the bill would require advance payment if a nursing facility has not received Medicaid payment within 30 days of an approved application. Medicaid is the payer of last resort after other payment sources, such as Medicare and private insurance. The coordination of benefits can often exceed 30 days, which under this bill, would result in advance payments to nursing

facilities. Although other sources may ultimately pay, the administrative burden of issuing advance payment and then obtaining reimbursement would create a significant administrative burden for the department.

Over the past year, as a result of ongoing, regular discussions with the industry, the department has and continues to modify our internal processes with regard to the eligibility determination for long-term care Medicaid clients. For example, the department has developed less labor-intensive asset review processes for both DSS and the applicant. In addition, we have rewritten several forms so that they are more consumer-friendly. Finally, with the assistance of the nursing home industry, the department is developing a dedicated long-term care Medicaid application that is specific to the financial and categorical requirements of a long-term care eligibility determination.

In addition to these discussions with industry leaders, staff from nursing facilities and home care agencies meet regularly with the department's eligibility and policy staff in an effort to enhance communications and resolve specific concerns as they arise.

The department opposes the legislation as it is proposed here, but will continue to work with the industry to come up with less costly solutions.

SB 1026 AAC an Adequate Provider Network to Ensure Positive Health Outcomes for Low Income Residents

This bill seeks to establish a commission to study access to Medicaid, including such aspects as the provider enrollment process, provider education, reimbursement, and means of improving health and cost outcomes and reducing racial and ethnic disparities. The department feels that these matters already fall squarely within the jurisdiction of the Medical Assistance Program Oversight Council which has a subcommittee dedicated to consumer access issues. Creating a new and separate commission would, therefore, be a duplicative effort.

HB 5919 AAC Presumptive Medicaid Eligibility for Home Care

While we generally support presumptive eligibility as a means of enabling access to services, we have several concerns about this bill.

The bill does not recognize that when an application is pending a Medicaid eligibility determination, there is no way for the system to permit payment to provider agencies. Thus, all claims would have to be held until the Medicaid determination is complete and the application is approved or denied.

The bill calls for an Access Agency to develop a screening tool. If a screening tool were to be created, it should be uniform and developed by the department as the agency that administers the program. Otherwise, this sets up the potential for incongruent standards across the state.

The timeframes laid out in the bill would be difficult for the department to achieve due to the complexity of the application process, which is the equivalent of a long-term care eligibility assessment. Furthermore, home care recipients require a level-of-care assessment and development of an appropriate plan of care as part the eligibility process that would make meeting the timeframe requirements extremely problematic.

The bill also calls for funding from the Older Americans Act (OAA). While the OAA funds a variety of health, supportive and in-home nutrition and caregiver services that all support the state's rebalancing efforts away from institutional-based care to community-based care, these funds are not allocated to subsidize actual care plan costs.

In addition, applicants who are ultimately denied Medicaid eligibility, which we believe to be between 25-30% of the waiver applicants, would be responsible for the mandatory 6% cost share (which the department would not likely recover, representing a budget impact).

The proposed methods for implementation of presumptive eligibility in this bill are not practical from an logistical standpoint. Ultimately, the result would be increased costs under the state-funded portion of the program that the state is in no position to absorb.

HB 6544 AA Establishing a Task Force to Study Price Gouging During Release of Federal Supplemental Nutrition Assistance Program Funds

The department feels that it would be beneficial to explore the issue of price gouging due to allegations of food stores engaging in price gouging coinciding with the issuance of Supplemental Nutrition Assistance Benefits on a monthly basis to program beneficiaries.

We have anecdotally heard that some stores may engage in this practice during the first two weeks of each month when the majority of SNAP benefits are redeemed. However, to our knowledge definitive data has not been produced to support such claims. A task force, such as the one contemplated in this bill, may be able to produce some substantive data to inform the conversation.

HB 6545 AAC Drug Prior Authorization for Medicaid Recipients

This bill would require the department, within 24 hours after a prescription is denied or partially denied, to issue an individually tailored notice to the client, identifying the drug in question, the reason for the denial/partial denial, procedures for appealing and options for obtaining a temporary supply/substitute drug. Additionally, within two days of the denial/partial denial, the department would be required to send notice to the prescriber, providing information about prior authorization requirements and procedures as well as alternative drugs not requiring prior authorization. If the prescriber does not submit a request for prior authorization or substitution after 12 days, the department would be required to contact the prescriber to discuss those options.

Prior Authorization (PA) is common practice among all insurers, including those in the private insurance market. When DSS implemented PA, we worked very hard to ensure that consumer safeguards were in place. We have contracted with HP Enterprises to administer prior authorization on our behalf. Currently, the department will allow pharmacists to dispense a one-time 14-day fill of a medication when prior authorization is required and the prescriber has not yet requested/obtained a prior authorization. Additionally, the Department developed and issued a flyer to all pharmacies to provide to our clients when a 14-day fill has been provided to them. This flyer notifies them that (1) only a 14-day fill has been provided, (2) prior authorization from the prescriber is needed in order to receive medication beyond the 14-day fill, and (3) they should contact their prescriber to request prior authorization or change the prescription. Additional safeguards are also in place to protect and enhance access, such as two-hour turnaround on all prior authorization requests, 24/7 operational access, simplified PA forms, follow-up on all mental health drugs after a 14-day fill has been provided, and several other protections.

Another important note is that there are other reasons that arise, not related to PA, which prohibit clients from obtaining their medication. For instance, a client may not eligible for the program because his/her coverage has been discontinued or a spend-down needs to be met. There might also be a problem with primary coverage such as Medicare Part D or other third-party payer. These issues are truly not related to needing prior authorization, but the bill does not distinguish between these types of situations.

Moreover, mailing of notices as suggested by this legislation is cost-prohibitive. The department requested our contractor, HP Enterprises, to develop cost estimates for expansion of their scope of work and for the actual mailing of notices. These cost estimates are dependent on the type of notification generated to recipients/prescribers; accordingly, one-time costs could range from $11,280 to $22,560, with annual recurring costs ranging from $417,600 to $489,000. These funds are not included in the Governor's budget.

For the above reasons, the department does not support this proposal. We offer, however, as an alternative to issuing notices when prior authorization is required, that prescribers be strongly encouraged to implement e-Prescribing. E-Prescribing allows prescribers to review recipient eligibility, medication history, formulary and prior authorization requirements prior to writing a prescription and avoids issues that may arise when consumers arrive at the pharmacy. While participation in e-Prescribing has increased, there is still a need to encourage the use of the various e-Prescribing tools available to prescribers.

Thank you for the opportunity to testify today. I welcome any questions you may have.